VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 26, 2014

Mr. Mike Jensen, Administrator
Wintergreen Residential Care Home
3 Union Street
Brandon, VT 05733-1127

Dear Mr. Jensen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 28, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted with a re-licensure survey on May 28, 2014 by the Division of Licensing and Protection. There were no regulatory findings surrounding the complaint investigation. There were regulatory findings involved with the re-certification survey.	R100		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the data, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R171		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PMC

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R171	Continued From page 1 facility failed to maintain a record of monitoring for side effects for 1 of 3 residents. Findings include: During record review on 5/28/14 at 4:30PM, there was no record of AIMS testing or other monitoring being performed for Resident #2. Resident #2 was admitted to the home on 4/11/14 with a diagnosis of Dementia with agitation and a history of overmedicating with controlled substance, Ativan. H/she has been evaluated by a psychiatrist and the primary care physician that indicates h/she is currently on the lowest effective dose of medications. Per review with the owner/manager at this time, h/she was unable to locate documentation to provide evidence that AIMS testing was done or other monitoring tool. Per phone interview at 4:48PM with the Registered Nurse, h/she confirmed that there has not been an AIMS done for Resident #2.	R171 5.10	The action we will take to correct this deficiency is, the RN will complete AIMS testing on Resident #2 as this resident is now receiving Psychoactive medications. The RN will ensure this doesn't recur by immediately completing the Aims test upon admission. The Corrective actions will be monitored by the manager so this does not recur. The corrective action will be completed by June 17, 2014 R171 POC accepted 6/19/14 BBartell RN/PM	
R181 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and	R181		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R181	Continued From page 2 checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure that the required background checks as defined in 33 V.S.A. Chapters 49 and 69 were completed on 5 of 5 employees reviewed, before date of employment. Findings include: 1.) Reviewed employee records of 5 employees hired since May of 2013. In review of the employee files it was found that 1 employee (#4) that had a start date of 7/13/13, there was an informed consent to obtain Adult Abuse (AA) registry background check, but there was no evidence of the results returning. This was confirmed with the owner/manager at 1:15PM on the date of the survey. H/she did not understand how it was missed and not sent to the State for review. This employee also did not have Child Abuse (CA) registry checks returned until 7/23/13. This was confirmed by the owner/manager. 2.) Employee #1 had a start date in October of 2013 and the CA did was not obtained until 4/4/14. At 1:15PM, per interview with the owner/manager, h/she stated that during review h/she was unable to locate the results and asked that it be obtained again. H/she could not verify the reason for the 6 month delay in review. 3.) Employee #2 began work 2/10/14 and his/her Vermont Criminal background check was not	R181 5.11	• The action we will take to correct this deficiency will be adding the correct start date to employees folder, Criminal + Abuse background checks will no longer be sent through the mail, they will be done electronically. • The changes we will make to ensur this doesn't recur will be to do all background checks electonically over night, before training is authorized. • The corrective actions will be monitored by the owner & manager by checking dates & paperwork together. • the date this action will be completed by is June 17, 2014	

R181 POC accepted 6/19/14 BBartell RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R181	Continued From page 3 obtained until 4/10/14, the AA on 2/19/14, 9 days after the start of employment and the CA 2/13/14, 3 days after the start of employment. Per interview with the owner/manager, h/she said that the forms do not always return from the State in a timely manner and h/she confirmed that the required background checks were not completed per regulation. 4.) Employee #3 began work 2/27/14 and did not have Vermont Criminal (VC) and Child Abuse (CA) registry checks returned until 3/13/14. This was confirmed by the owner/manager at the time of review. 5.) Employee #5 began work 3/10/14 and only worked for 2 hours. The CA did not return until 3/17/14 and the AA returned on 4/14/14. Confirmed by the owner/manager that Employee #5 was not alone with residents and only worked 2 hours before quitting.	R181		
R214 SS=B	VI. RESIDENTS' RIGHTS 6.2 Each home shall establish and adhere to a written policy, consistent with these regulations, regarding the rights and responsibilities of residents, which shall be explained to residents at the time of admission This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to establish a written policy regarding the responsibilities of residents. Findings include:	R214 6.2	The action we will take to correct this deficiency is to complete a written policy regarding residents rights + responsibilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 06/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R214	Continued From page 4 On May 28, 2014 at 4:30PM during record review and resident interviews, 3 of 3 residents interviewed stated they were not aware of any "house rules" that were established by the facility. In review of the records, there was no evidence of "house rules" being included. Per interview with the owner/manager at this time, h/she stated that there were no written policy regarding resident responsibilities.	R214	The changes we will make to ensur this doesn't recur will be to, add a copy to all admission folders and explained at time of admission, also as we update other notices annually we will post the residents "House Rules" also.	
R232 SS=B	VII. NUTRITION AND FOOD SERVICES 7.1.a.(1) Menus for regular and therapeutic diets shall be planned and written at least one (1) week in advance. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to post planned and written menus at least one (1) week in advance. The findings include: On 5/28/14 at 11:40AM, during tour of facility, there was no evidence of a menu for breakfast meals posted. Per interview with caregiver that was responsible for meal preparation for the day of the survey, h/she stated that the residents have choice of what they want for breakfast and it varies from day to day. H/she stated that there are some residents that will eat the same breakfast every day and they are always offered fruits, oatmeal, dry cereal, eggs, toast or french toast. H/she did confirm that there was no written menu to follow. Per interview with house manager at 1:00PM, h/she confirmed that there is no specific written menu for the breakfast meal.	R232	The corrective measures will be monitored by the Owner + manager as both are present during new admission. The corrective action will be completed by June 17, 2014 R214 POC accepted 6/19/14 BBartell RN/PMC	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R233 SS=B	VII. NUTRITION AND FOOD SERVICES 7.1.a (2) The meals served each day must provide 100% of the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans. This REQUIREMENT is not met as evidenced by: Based on review and staff interview the facility failed to provide 100% of the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and comply with the Dietary Guidelines for Americans. Findings include: During review of the facility menus on 5/28/14 at 1:15PM, it was found that for the menus posted for the time frame of 5/25-5/31/14, the facility failed to have three to five one-half cup servings of vegetables for 3 out of 7 days. The facility also failed to provide 4-6 ounce portions of meat per day for 3 of 7 days and did not provide evidence that 6-11 servings of bread/cereal/rice/pasta or equivalent were served for 5 of 7 days. Per interview with house manager at the time of discovery, h/she stated that there is a provision and offerings of the equivalency, but is h/she is unable to provide the evidence secondary not having a written and posted breakfast menu.	R233 7.1 7.1 7.1	The action we will take to correct this deficiency is to immediately post a Breakfast menu and provide 100% of the RDA on the menu, as established by the food & nutrition board. The Changes we will make to ensure this doesn't recur is to keep a breakfast menu posted at all times and to make sure what we offer daily is 100% of the (RDA). The Corrective actions will be monitored by the house manager to ensure 100% nutrition is provided.	
R999 SS=A	MISCELLANEOUS Based on observation and staff interview, the facility failed to make written reports resulting	R999	The corrective action will be completed by June 17, 2014	

R232 POC accepted 6/19/14 BBonfield RN/PMC
+R233

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R999	Continued From page 6 from inspections available to residents and to the public as required under regulation 4.14.f. Findings include: On 5/28/14, during tour of facility at 11:30AM, there was no evidence to show that the facility had made available the survey inspection reports. Last re-certification survey was 5/13/13 and per interview with owner/manager at 4:30PM, the results were available upon request. Reviewed regulation and gave guidance regarding need to have posted in accessible public area.	R999	The corrective action we will take to correct this deficiency is to post the most current copy of inspection where residents + the public can view it. The changes we will make to ensure this doesn't recur will be posting results of inspection as soon as its received. The corrective actions will be monitored by the owner, as the results of the survey will be mailed to her. The corrective action will be completed on June 17, 2014	

R999 POC accepted 6/19/14 BBortell RN/pmc